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Advance Care Planning at a Rural FQHC: A Pilot Project

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BACKGROUND

California State University, Monterey Bay's (CSUMB) Department of Nursing partnered with San Benito Health Foundation (SBHF), a Federally Qualified Health Center (FQHC), to plan palliative care services in a rural community. The planning phase occurred from January – June 2017 and this project is now at the beginning its implementation phase.

SBHF is a patient-centered health home providing medical, dental, and prenatal services to a largely Hispanic patient population, including migrant farmworkers.

We identified an opportunity to integrate advance care planning (ACP) into case management appointments for clients with Type 2 Diabetes Mellitus (T2DM) who had a recent A1C >7 mg/dl.

ACP is defined as “a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care” (Sudore et al., 2017, p. 6).

PURPOSE

- To increase client engagement in their healthcare decisions through ACP
- To optimize the Electronic Health Record (EHR) to document advance care directive education and conversations.

PROCEDURE

Target Population

- 423 clients diagnosed with T2DM and an elevated A1C
- Previous no-show for case management appointment

Staff Training

- 7 SBHF staff enrolled in the Case Management Excellence course through the CSU Institute of Palliative Care.
- All staff will receive an in-service about ACP and completing directives.

Patient Engagement

- Clients in the target population were individually contacted through phone and mail to book an hour long case management (CM) appointment at SBHF.

Advance Care Planning

- Staff began introducing advance care directives to clients during their CM appointments and providing them with culturally and linguistically appropriate educational materials. Staff worked with the IT team to include ACP documentation in the EHR.



SBHF offers nutrition education sessions for their clients.



The entrance to SBHF's patient-centered health home.

EVALUATION PLAN

We will track and assess the following metrics to evaluate success of the program over the next 6 months. These include:

- Patient satisfaction
- No-show rate for CM appointments
- EHR documentation of ACP during appointments
- Staff perceptions of ACP

ACKNOWLEDGEMENT

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REFERENCE

Sudore, R. L., Lum, H.D., Hanson, L.C, Meier, D., Pantilat, S.Z., Matlock, D.D.,...Heyland, D.K. (2017). Defining advance care planning for adults: a consensus definition from a multidisciplinary delphi panel. *Journal of Pain and Symptom Management*, 16(3). 1232-1235. Doi: 10.1016/j.painsymman.2016.12.331